CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Appeal Request Form

Standard and Utilization Management

☐ 1st Level ☐ 2nd Level ☐ Administrative Review

DETAILED INSTRUCTIONS ON LAST PAGE

*PROVIDER NAME	*PROVIDER TAX ID
*PROVIDER ADDRESS	CONTRACTED ☐ YES ☐ NO

PROVIDER TYPE

☐ Physician ☐ Hospital ☐ Dental ☐ SNF ☐ Rehab ☐ Ambulance ☐ Other (Specify type) _____

*CLAIM INFORMATION

☐ Single ☐ Multiple** "LIKE" claims, same dispute and outcome (complete page 2) # of claims _____

***If there are multiple claims with different dispute and expected outcomes, they shall be sent separately.*

*PATIENT NAME	DATE OF BIRTH	
*CDCR NUMBER	*INVOICE/PT. ACCOUNT #	*CCIH CLAIM NUMBER (If multiple "LIKE" claims, use page 2)
*SERVICE FROM/TO DATE	ORIGINAL CLAIM AMOUNT BILLED	ORIGINAL CLAIM AMOUNT PAID

DISPUTE TYPE

Contract underpayment Appeal of medical necessity/utilization management decision MUE denial DRG
Claim denied as duplicate Eligibility Other _____

*DESCRIPTION OF DISPUTE (Indicate reason for dispute, provider's positon and reasoning. Additional pages can be attached)

*EXPECTED OUTCOME

*CONTACT NAME	TITLE	*EMAIL ADDRESS
*PHONE NUMBER	FAX NUMBER	

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Multiple Claims Information

#	PATIENT NAME		DOB	CDCR #	CCIH CLAIM #	SERVICE FROM/TO DATE	ORIGINAL CLAIM AMOUNT BILLED	ORIGINAL CLAIM AMOUNT PAID
	LAST	FIRST						
	Sample:							
1	Doe	John	1/1/1989	AB12345	2022-123456789-0000	1/1/2022 – 1/3/2022	$100.00	$50.00

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INSTRUCTIONS/REQUIREMENTS

- Form fields with an asterisk (*) are required.
- The *DESCRIPTION OF DISPUTE* section **must** include a detailed narrative of what is being appealed and justify why payment and/or additional payment is due.
    - Documentation supporting the justification for appeal in the *DESCRIPTION OF DISPUTE* section must be included with **all** levels of appeals. Any additional/unrelated documentation may not be reviewed.
    - Additional documents required are:
        - Related claims
        - Related explanation of benefits (EOB)
- The *EXPECTED OUTCOME* section **must** include a detailed narrative of the expected appeal outcome.
- 2nd Level Appeals **must** include:
    - New Appeal Request Form.
    - Supporting documentation not previously submitted in the 1st level appeal.
    - Copy of the 1st level appeal denial letter.
    - Related claims and EOB(s).
- All previous appeals **must** be included with an Administrative Review.
    - Additional information regarding these reviews can be found in the Provider's Health Net Federal Services contract.
    - Non-contracted Providers may contact the HIS Appeals Support email address for additional information.
- Completed forms and status/inquiries shall be emailed to: HISAppealSupport@cdcr.ca.gov.

PLEASE NOTE: *If an appeal is submitted without the above requirements, it may be canceled and returned. It is the responsibility of the Provider to submit a new, complete appeal for processing.*